MEETING

STATE OF CALIFORNIA

HEALTH AND HUMAN SERVICES AGENCY

RURAL HEALTH POLICY COUNCIL

GUALALA ARTS CENTER

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APPEARANCES

COUNCIL MEMBERS

David Carlisle, Chair
M.D., Ph.D.
Director, Office of Statewide Health Planning
and Development

Wm. David Dawson, Chief Deputy Director
California Department of Mental Health

Brenda Klutz, Deputy Director
Department of Health Services

Mauricio Leiva, Operations Manager
Managed Risk Medical Insurance Board

Morgan Staines, Staff Counsel
Department of Alcohol and Drug Programs

ALSO PRESENT

Bud Lee, Interim Executive Director
California Health Policy Council

Kerri Muraki, Rural Jobs Coordinator
California Rural Health Policy Council

Lauri Paoli, Executive Director
California State Rural Health Association

Del Armstrong
Department of Health Services

Cheri Voisine
California State Rural Health Association

I N D E X

P R O C E E D I N G S

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CHAIRPERSON CARLISLE: Welcome to the meeting of the California Rural Health Policy Council. I'm Dr. David Carlisle, Director of the Office of Statewide Health Planning and Development. We're going to start off the meeting with a set of introductions from the Council representatives, and then go ahead and proceed further down the agenda. And why don't we start all the way to my left.

COUNCIL MEMBER STAINES: Thanks Dr. Carlisle.

I'm Morgan Staines, from the Legal Office of the Department of Alcohol and Drug Programs. And my Director, Kathryn Jett, sends her greetings and her regrets that she can't be here herself.

I, on the other hand, am delighted to be here. It doesn't bother me at all that she can't come, because I always enjoy these meetings, and the opportunity to meet some of our rural constituents and see what the needs are.

COUNCIL MEMBER DAWSON: I'm Dave Dawson, Chief Deputy Director of the Department of Mental Health, representing Dr. Mayberg, who also could not be here today.

COUNCIL MEMBER LEIVA: I'm Mauricio Leiva, the Operations Manager for the Health Department's program, the Managed Risk Medical Insurance Board, and I'm representing Sandra Shewry.

COUNCIL MEMBER KLUTZ: My name is Brenda Klutz, I'm the Deputy Director for Licensing and Certification, and I'm representing Dr. Diana Bonta', the Director, Department of Health Services.

CHAIRPERSON CARLISLE: Okay. Well, thank you all for being here, and I think we'll go ahead and just proceed to Agenda Item Number 2, which is the Executive Director's Report.

INTERIM EXECUTIVE DIRECTOR LEE: Thank you very much, Dr. Carlisle.

I'm Bud Lee, the Interim Executive Director of the Rural Health Policy Council. I have a few things to update people on.

First of all, the recruitment is still underway for the permanent Executive Director for the Council. And so if anyone has any candidates that are perhaps working for counties now that would like to be considered for this job, if they would please get in touch with me I'd appreciate it.

Just a quick update on activities of the Council. For the past few months the Small Services Grants Program requests for applications is underway. We've sent out 300 packets, had a bidders' conference on May 8th. We posted the questions and answers from the bidders' conference on our Website. The attendees asked for a list of last year's awardees, and with the funding amount and one-line

description of the projects that were funded. And we posted these also on our Website. And copies of both the Q and A's and the lists of last year's successful projects are available on the table at the side of the room.

The application due date is June 14th. The review process will begin July 1. If anyone is aware of someone who would like to help us out on the review panel, they cannot be an applicant, obviously, but if they would like to help us review the applications, if they would please let the office know, we would appreciate that.

We have also just an update on our jobs available program. There are a total of 146 job opportunities listed on our jobs available program. This is on our Website, also. Ninety are in the north, 40 are in the central region, and 16 in the southern region. Of this total 105 are for patient care positions, 10 are ancillary positions, and 31 are for administrative positions. And copies of this summary are available also on the table at the side of the room.

We also mailed out job surveys to all providers regarding the usefulness of the jobs available service. There's been a good response. If you have not had this, or if you have one, it's only a seven question survey, so please take the time to respond. The survey's also available on our Website, as well as at the table on the

side of the room there.

We're starting to assemble some clinic information. In May we sent out surveys to the clinics on the Department of Health Services clinic list. The current lists include closed clinics, and don't include recently opened clinics. And the purpose of this survey is to give us a comprehensive listing of all rural clinics and facilities in the state, and this listing will give us the contact names at each facility, give us an idea of who is provider based, federally funded, certified, licensed, those kinds of demographics.

The survey information will be collected until May 31st. That's the end of this week. And the survey is available on our Website, and also at the table at the side of the room.

With regard to critical access hospital program, we completed this year's application and will continue the critical access hospital program. The application has been submitted to the federal government. Currently, there are 11 hospitals certificate as critical access hospitals in rural California.

And with regard to the rural hospital list, the official OSHPD list of rural hospitals was updated recently to reflect the actual number of acute care hospitals that are still opening and functioning as rural general acute

hospitals. Hospitals that exceeded the maximum number of acute care beds that were identified on the last list were deleted from the original list.

And lastly, at the last public meeting there was some discussion about difficulties rural health providers were having with some of their managed care plans. And so we have initiated a dialogue with the Department of Managed Healthcare to see if we can find out some guidance from them on how to deal with some of the particularly unique situations that rural hospitals and clinics are facing with regard to managed care plans. And that's a dialogue that has just started. If anyone would like to be a part of this dialogue, they should get in contact with us. They can get my card, or give me your card, and I'll make sure that you are in this loop.

This is also a part of a bigger effort that is coming our way. There is -- the state budget process is now in full swing. I think, as many of you know, there is some budget language that requires OSHPD, with the Rural Health Policy Council, to produce kind of a status report on rural health delivery in California. That report is due in February 2003. The intent here is to try to document the situation profile of rural health in California, including the financial status issues that may be resolved administratively; what the role is of the small grants

program; what the role is of the capital grants program which was not funded for this year; what the role has been of the rural demonstration grants through Mr. Neve; other issues related to seismic safety compliance, HIPPA compliance; managed care; all attributes of the operating environment that the rural health system is currently experiencing. So that when the state's general fund condition recovers, and there are dollars available to reallocate to programs which have had to have been cut this year because of the general fund condition, we won't have to start then documenting what the situation is with regard to the rural health policy in communities because we will already have done that, it'll have been done by an objective state body with lots of input from stakeholders; therefore, it has more of the perspective of something that legislators will be able to rely upon when they have more discretionary funds available in the future. We hope.

So that is the sum of my report, other than to also remind you again, if you know of anybody that would like to be an Executive Director of the Rural Health Policy Council, currently working for a county, and is able to work out a relationship between the county and the state, I would love to talk to them.

Thank you very much.

CHAIRPERSON CARLISLE: I think because of the

informal setting we'll go ahead and ask, first, do any of the Council Members have any questions for Bud Lee, based on the report? And I think we can just go ahead and open it up to the floor, actually, since the floor is rather small. Any floor questions for Mr. Lee?

MS. PAOLI: Hi, everybody. I'm glad to be here. I'm Lauri Paoli, the California State Rural Health Association.

Bud, I'm curious if a county person who's retired is a person who could apply for the position. There was a woman in southern California, the new reformed southern California rural roundtable, who's interested, and --

INTERIM EXECUTIVE DIRECTOR LEE: This is my understanding, but I'll follow up because I'd like to consider anyone from the county. They have to have a relationship of some kind with a government body other than the state.

MS. PAOLI: A present relationship.

INTERIM EXECUTIVE DIRECTOR LEE: A present relationship. So if they have, you know, a retired annuitant category or something like that, that someone has, if that's available, we can look at that.

CHAIRPERSON CARLISLE: Yes. And be sure to introduce yourself.

MS. ARMSTRONG: My name is Del Armstrong. I work

for the State Department of Health Services in Managed Healthcare. I am a first line supervisor or a manager over two plan counties, which include 12 counties and the State of California, and many of them are rural. And I met some of the people last meeting and listened to the problems that they're having pertaining to the rural areas. And your committee, the committee we're talking about and the Department of Managed Care also working with you, I may be interested, but I wasn't sure exactly what it entails. But I could talk to you later about that.

INTERIM EXECUTIVE DIRECTOR LEE: Sure. Absolutely.

MS. ARMSTRONG: Thank you.

CHAIRPERSON CARLISLE: Thank you.

Other questions? Why don't we go ahead and move forward. Next on the agenda is a presentation by Brenda Klutz, from the Department of Health Services. Brenda.

COUNCIL MEMBER KLUTZ: Thank you, Dr. Carlisle.

I just wanted to give you a very brief overview of what AB 394 does and the process we've gone through to develop the hospital minimum nurse staffing ratios.

As you probably know, AB 394 required the department to establish minimum nurse to patient ratios by hospital unit, and it specifically mentioned the units by name in the bill. It also required that the patient

classification system, that is the acuity based system that hospitals use to increase staffing based on acuity, would stay in effect and would be on top of the minimum. So that is not changing. Also, it required us to give special consideration for rural hospitals, in terms of meeting the staffing ratios.

So, as you probably know, California is the only state in the nation that has some units with minimum staffing ratios requirements already, in intensive care, critical care, the operating room, and in the well baby nursery. And those requirements have been in effect since the 1970s. But expanding this hospital-wide to cover every unit is another first for California, and again, other states have looked at this, but we will be the first state to actually promulgate hospital-wide ratios.

What we did to try to get our hands around what those ratios should be is we contracted with the University of California at Davis to do three things. To do a literature search to see if there was any research or data that we could use to justify the ratios; to analyze the very extensive data collected by the Office of Statewide Health Planning and Development, OSHPD, to give us a baseline or a feel for how hospitals were actually staffing. And then also, part of the bill requires us five years after the ratios go into effect to submit a report to the legislature

analyzing the effect of the ratios on patient care. And so the third part that we contracted with UCD for was to begin some very preliminary work, to convene an expert panel to identify those conditions or those diagnoses that were more sensitive to nursing care, direct nursing care.

So the results of the literature search, first of all, they identified almost 3,000 articles, research articles, internationally and nationally, that might be of assistance. They, after a little bit of review, they identified 456 for close review; 419 of those articles were eliminated because they lacked key information necessary for relevance on setting ratios. So basically, it boiled down to 37 articles that had any relevance to establishing ratios.

However, after thoroughly reviewing even those articles, the conclusion is there is no hard scientific data that indicates a magical number, a minimum number of nurses per patients that can safely and effectively handle all providing patient care. So that was a little bit discouraging, because obviously it would've been a much easier task if there had been some groundbreaking research. However, in recent months there have been two research studies published dealing with increasing the amount of licensed nursing staff in ICU and CCU, and the resultant decrease in mortality, morbidity, length of stay, hospital

returns, so we do know that there's a direct link between adding licensed nurse staffing and quality patient care. But again, it didn't point to any particular numbers.

The next task was to look at the OSHPD data. As you know, the California OSHPD collects by far more comprehensive data about hospital usage and staffing than any other state in the nation. The data is for all acute care hospitals, except for Kaiser, and it includes an inventory of provided services, number of beds, productive nursing hours per patient day, and number of patient admissions and discharges, just to name a few elements. But those elements would be most pertinent to some of our work.

However, for purposes of establishing minimum ratios, we found that the productive hours per patient day did not -- we weren't able to extract bedside nursing hours, per se, because that data also includes training, quality assurance, and management, all very important functions. But again, we're looking at bedside nursing ratios.

Then the third area, again, I mentioned, was an expert panel was convened and identified some conditions that were more sensitive to nursing care for our five-year review. After UCD concluded these tasks last year, we reconvened, and the director really decided that we needed to get a real time feel for how hospitals were actually

staffing. And so we worked with UCD to design a data collection tool. Seventeen of our surveyor nurses, all of whom had had experience working in hospitals, did unannounced onsite surveys, measuring staffing levels in hospitals.

We took a stratified sample of all California hospitals, sorted it in six categories. We had academic medical centers, we -- over-sampling for Kaiser, small and rural, other publicly owned hospitals and private and state facilities. All told, we did onsite reviews of 80 hospitals. In addition, we measured the staffing at all ten state operated general acute care hospitals, so it was 90 hospitals all together.

And the type of data we collected was the type of patient classification system that the hospital used, and interestingly enough, most hospitals have developed their own. And, of course, the others have used vendorized software. But what we did was we looked at the actual staffing for each unit for the shift that was in progress at the time we set foot on the hospital, and the 24 hours before. Then we had the previous seven days of staffing for all shifts, and then we selected an additional ten days that would reflect holidays, weekends, like periods during the influenza season, to get representative samples of staffing throughout the year.

What we asked for are the number of nurses assigned; number of patients assigned to each nurse; the age of the nurse; the years at that hospital; the years in nursing; whether they were LVN or RN, and if RN, whether they were diploma, AA degree, BSN, MSN, or Ph.D. We measured whether the person was full-time, part-time, hospital per diem or registry. And we also looked at the nursing model used, whether they used team nursing or all RN staff. We also looked at the number of unlicensed assistant personnel that were assigned patient care tasks in each unit.

This database, by the way, as well as the other three parts of the UCD study, will be published on our Website along with the regulations, and made available to anyone who wants to review the results. And for researchers who actually want to get ahold of the database, we're going to make that available, as well, because it's probably the most extensive real time onsite validation of hospital staffing in the nation that's been done.

We looked at, when the data entry was completed it included over 1700 variables and 35,000 pages of data. So the reports that will be coming out will be showing the results of staffing by unit for each of these six types of hospitals, rural, public, urban, Kaiser, academic medical centers. So some very interesting analyses.

Also, we broke down the hospital location by MS, by health systems agency regional groupings, and it's very interesting to see those areas of the state that have a richer mix of nurse staffing than other parts of the state. So some very interesting data, I think, will be coming out.

We hope that the regulations will be coming out and made public within the next two to three weeks. It's going through the review process, and as you can imagine, with the budget right now, probably the timing for getting the package through and having finance and folks look at it, it's -- there's a lot of competing tasks that people are involved in. But people recognize the urgency of getting this out. And again, the regulations and all the supporting reports will be posted on our Website. We will have a Website for getting public comment.

We will be holding public hearings at least four places in the state. And those will take place late July, during the month of August, is the ballpark for the 45 day public comment period.

Some of the interesting dynamics of the regulations, without divulging the regulations again because they have not been finally approved, but as you know, currently we require that at least 50 percent of the licensed nurses in ICU, CCU, be registered nurses. There's been considerable controversy in terms of some groups asking

that the ratios pertain only to registered nurses. Other groups want us to prescribe the staffing mix. We think that the flexibility is needed because the scope of practice of each of the LVN, RN, licensed nurse categories, and the acuity of the patient really will dictate the staffing mix. And because, again, this is a very interesting piece of information for us, and I think it may be an indication of how the acuity has increased in hospitals. Hospital-wide, based on our survey, 18 percent of licensed nurses were LVNs. In ICU and CCU, three percent were LVNs. So, again, I think that acuity and scope of practice is really determining the staffing mix.

So we look forward to those regulations coming out, and the public dialogue. It's been a very interesting process. Our staff has taken so much care in crafting these regulations. The analyst writing the regs is a registered nurse who has worked in hospitals, has surveyed nurses -- surveyed hospitals, I'm sorry.

And I think that's it. I don't know if there's any questions.

CHAIRPERSON CARLISLE: Thank you very much, Brenda. And I'll go ahead and open it up for members of the Council to ask Brenda questions. I know Bud had one.

INTERIM EXECUTIVE DIRECTOR LEE: Brenda, if this goes into the area of the regulations that you can't talk

about yet, just say so. But I'm wondering if -- is a rule of Health Policy Council meeting. You mentioned very early a description that there were certain slices that you looked at in them. I know that there are folks in the rural health community that are wondering is there going to be any kind of sensitivity to the dynamics that are in rural hospitals?

COUNCIL MEMBER KLUTZ: Well, the survey results were very, very interesting, because I personally come from a rural community, and I know how difficult it is to recruit licensed healthcare professionals to rural areas, and it's a continual challenge. So frankly, we were very surprised to note that rural hospitals, I think without exception, had a richer nurse to patient ratio than urban hospitals. And that's not that they have more nurses. It's the ratio of nurses to patient. I mean, if you only have one baby in a well baby nursery, you still have to have one nurse.

The other thing I should mention, too, because of the particular rural consideration, is that we are also, you probably noticed on the chart on the front table that we're establishing minimums for what we call mixed units. And this is because many rural hospitals are not large enough to have separate and distinct, you know, oncology units, orthopedic units, pediatric units. And so you have patients with mixed care needs being in the acute care beds, and so that's kind of a special acknowledgment to rural hospitals,

that we're setting those ratios for mixed units at the same level as medical surgical.

Maybe a brief, very brief explanation of a couple of things on the chart. You'll notice that in some units there are two or more ratios. For a general med, surge and mixed units, the effective date of the ratios, which will be July 1st of 2003, the ratio will be one to six. And then one year after the effective date of the regulations, each of those units' ratios will be lowered to one to five.

The other one that may be confusing is emergency department. We're saying that overall the ratio needs to be one to four, but with trauma care, one to one; critical care, one to two. But those ratios exclude the triage nurse, and if a hospital has a radio nurse that's working full-time to deal with ambulance traffic and the EMTs, then that nurse is also excluded from the ratio because these are nurses that are providing direct patient care that we're focusing on.

And post partum, I think it's self-explanatory there. Overall there's one to eight, one to four couplets, that is mother and baby. Mothers only would be one to six. And in multiple births, again, the number of newborns and the number of mothers shall never exceed eight per nurse. And that's in the post partum, not in the labor and delivery.

So, just a bit of explanation about those ratios.

INTERIM EXECUTIVE DIRECTOR LEE: Thank you.

CHAIRPERSON CARLISLE: Thank you. Mauricio.

COUNCIL MEMBER LEIVA: Yes, I have a question regarding your Website, where we can actually look at the report, and your completion date?

COUNCIL MEMBER KLUTZ: Okay. Again, we hope within the next two to three weeks, but our Website is www.dhs.ca.gov.

Also, with the study we are comparing -- we had three, four major proposals that were submitted, one by the California Healthcare Association, one by the California Nurses Association, Service Employees International Union, and the United Nurses Association. In two instances, the associations actually drafted regulations. And we will have in our study, based on our onsite survey, the percent of hospitals that would be deficit in meeting these ratios, the number of additional nurses needed, and the projected cost of those additional nurses needed for our proposal and for each of the other three major proposals. So you really get a range of the impact of the minimums.

I should also mention that one of the very critical factors, too, in determining the ratios, was to look at recommendations by various other professional associations, such as the American Academy of Pediatrics,

Peri-Anesthesia Nurses Association, Emergency Room Physicians, the National Obstetricians -- Obstetric Nurses Association, excuse me. And so, again, we were very gratified to see that where the ratios that we had established were very much in sync with recommendations by professional associations, in addition to reflecting the best professional judgment of staff.

Thank you.

CHAIRPERSON CARLISLE: Other questions from the Council?

COUNCIL MEMBER STAINES: Yeah. Brenda, are you able to project when the rules would become effective if the hearing comments don't slow you down too much?

COUNCIL MEMBER KLUTZ: Well, we are actually putting July 1st of 2003 in the regulations as the effective date. Again, for a couple of reasons, we think that -- and frankly, that was one of the reasons that in January the governor announced the ratios, because people were very hungry to see where the department was coming from, give hospitals an opportunity to staff up. And because of the current fiscal climate, again, we did not want to make this a budget year issue for hospitals or for state facilities.

COUNCIL MEMBER DAWSON: Do you have any sense of what the net change in the nurse workforce will be in California after implementation of the ratios?

COUNCIL MEMBER KLUTZ: Well, again, I think the governor announced that we're estimating that the regulations would require an additional 5,000 licensed nurses. And again, we're not dictating the specific skill mix between LVN and RN.

And in varying degrees, many of the -- in some areas, hospitals, 90 percent of hospitals already meet the ratios. In units such as burn units, that's considered an ICU/CCU. One to two is not controversial. It's really standard of care, community standard practice.

The biggest impacts will be in med surge, behavioral health, and emergency department, pediatrics, telemetry, those areas.

CHAIRPERSON CARLISLE: Brenda, in terms of the public hearings, do you know where they will be scheduled at this point?

COUNCIL MEMBER KLUTZ: We don't know where yet. We want them to be throughout the state. And we are looking at at least one area where rural caregivers would find it easier to attend, whether that's Redding or Fresno, or -- we're limited by the number of hearings we can accomplish in the 45 day period, with everything else. But we do want to get the biggest, the broadest opportunity for people to comment. And again, testifying before the hearing, we do need to let people know, and we will let people know that

written testimony is just as effective as testimony in person. But we will have each of the hearings recorded, the recordings -- we'll have transcripts of the hearings, and we do have to address each and every issue that is raised in the public comment period.

INTERIM EXECUTIVE DIRECTOR LEE: If I could ask you if you could work with the Council office, also. We can post notices about times and places of meetings on our Website, just in case they don't go to yours. We could even have a hotline, perhaps, between --

COUNCIL MEMBER KLUTZ: That would be great.

CHAIRPERSON CARLISLE: At this point why don't we ask if there are questions from the audience for Brenda Klutz.

MS. PAOLI: Brenda, of the ten percent of the hospitals that don't meet the requirements currently, do you have an idea how many of those are rural hospitals?

COUNCIL MEMBER KLUTZ: No, I don't right off the top of my head. And I should clarify that some units, ten percent of hospitals don't meet. Other units, 25 percent, med surge is probably the largest at 40 percent of hospital -- I shouldn't say hospitals. I should say hospital shifts. Okay. Because we measured 30 or 40 shifts, and that's a very big difference between a hospital being deficit and having a single shift deficit.

So it really varies by unit. And the charts that will be coming out will be going down to that detail, in terms of rural hospitals and the rate of deficiency by unit, by shift.

MS. PAOLI: Was there any other information in the research that was conducted that was particularly special, or of interest to rural?

COUNCIL MEMBER KLUTZ: We didn't ask that question in the literature search. The literature search was geared exclusively toward information that could guide us on what the ratios should be. And if there was anything, whether rural or urban, that would have been used. But there was nothing specifically related to setting ratios.

The only thing that we have for rural hospitals is the onsite survey, and the results of that. And we can split out the nursing skill mix, et cetera, for rural, the rural hospitals that we're serving. So, again, we'll make that database available, and if there are groups that would like access to the data itself, not just the reports. But the report, it's probably a four-inch binder for all four reports. Those are the summary reports, in addition to the regulations.

MS. PAOLI: Can I ask one more question. In terms of the net change impact for the workforce, the 5,000 number, that doesn't include already the deficiencies that

are out there right now?

COUNCIL MEMBER KLUTZ: That was based on the deficiencies in the hospital shifts as of May of last year. So to the extent that hospitals had added staff, that would reduce the deficiencies. Or similarly, if hospitals have more of a deficiency in staffing than they had last year, then it would exacerbate that. But that was in May of 2001, that measured the deficiency at that time.

MS. PAOLI: So it includes the current deficiency based on the current regulations, and then in addition to that, the new regulation.

COUNCIL MEMBER KLUTZ: Well, when you say current, current as of 2001. If hospitals have hired more nurses then it reduces the deficiency. But we don't, we haven't done a comparative survey, although we may before the end of the five-year analytical period.

MS. PAOLI: Thank you.

CHAIRPERSON CARLISLE: Other questions?

Yes, go ahead. Introduce yourself, also.

MS. VOISINE: I'm Cheri Voisine, with California State Rural Health, as well.

I was wondering if you could kind of give us a picture of what the enforcement will look like, and what timeframe that'll be and what will the consequences be for hospitals that don't meet the requirements.

COUNCIL MEMBER KLUTZ: Okay. Well, basically, the enforcement will be the same as the enforcement for ICU and CCU right now. The consequence is the deficiency, and requiring a plan of correction for how the hospital is going to correct. There are, as you know, no civil monetary penalties or fines for this or other deficient practices, except for in -- and again, we will, this is another area where we really grappled with describing it. We do, we are trying to address the issue of unanticipated admissions to a unit as a basis for perhaps temporarily, I mean, not meeting the ratios. And we go into detail on what unanticipated is, and it's, you know, the emergencies, the trauma cases. The train crash in Orange County is an excellent example, although I think by the time the folks arrived the community had responded so significantly that there was no lack of staffing to assist.

But we will be taking the same approach that we take now for ICU and CCU. Again, basic hospital practice is that the charge nurse looks at the ER, you know your elective surgery schedules before the beginning of the next shift, and attempting to make those adjustments for any extraordinary fluctuations. Looking at the discharges during which shifts. So we don't see any difference in terms of our enforcement approach for these ratios.

MS. VOISINE: Thank you.

CHAIRPERSON CARLISLE: Well, thank you very much for that excellent presentation, Brenda.

And just moving ahead on the agenda, we're now into Item 4, Roundtable Discussion and public comment. Ordinarily I think we might be collecting cards from people, but I think that just because of the setting we can just ask if there are some questions that you'd like to ask the members of the Council directly.

MS. PAOLI: This is Lauri Paoli of the California State Rural Health Association.

I assume that the lack of attendance from the rural roundtable is not an indication that they're not appreciative of everyone being here. I'm not really sure what that's about.

However, we'd like to ask if the Council thinks that the importance of an Executive Director for the Rural Health Policy Council is something that they're considering, and maybe could talk a little bit more about, especially given the current freeze of positions in the state.

INTERIM EXECUTIVE DIRECTOR LEE: Well, actually this position is one of those rare positions that has been approved for hiring. The problem has not been the freeze. We're looking for someone with some rural experience, someone that has some -- I mean, I can't say it any plainer than that. Someone that has some hands on rural experience.

And through a variety of associations that was included, you know, we've tried to reach out and see if there is an interest. It's been about, you know, ten months now that the position has been open. And I have started more recently kind of increasing my level of involvement as an Interim Executive Director, just because it was becoming clear that the recruitment process was facing challenges that I did not anticipate.

Some of the -- kind of the back channel feedback that we're receiving is that it is always difficult to recruit from areas other than in Sacramento for people to come to Sacramento in an election year, because this is a position that is not civil service protected. And even in a contract situation, like with a county, you know, were there to be a changeover in administration there is no certainty of a contract being renewed. And I can understand that. People might be more reluctant to do that so close to an election.

So I think that might be kind of retarding our efforts a little bit, in getting -- in even getting candidates' names in front of us. At an earlier meeting this month with the County Medical Services program, it was kind of a bittersweet message. They said that there may be some more candidates out there because there may be some layoffs coming at the county level.

So our efforts have been as diligent as we can make them, reaching out to everyone that we can that knows people in these situations. And so my commitment, until that is done, is to find the time that I can get to increase my level of involvement as an Executive Director, and the initiating of dialogue with the Department of Managed Healthcare is kind of the first piece of that. I was fortunate because I know some people over there that we can work with very well.

And that's really just the beginning. We also have this other task with regard to the budget language. We're not going to wait until the budget gets passed with that language in it in order to start. It's a pretty, I mean, there's no dissenting votes on it. We may as well assume that it's going to be a part of the budget and get started on it now. And so you're going to be among the folks we start talking to here, you know, fairly soon.

So I hope that the performance of the Council will not be, you know, considered lagging just because we can't accomplish the recruitment effort in a manner as timely as we would like to. We're going to still be as aggressive as we can as an advocate for the rural health community, and we're going to, you know, expect you to keep us sharp on that.

MS. PAOLI: And I have one other question. The

nurse ratio regulations that are coming out is another recognition of the need for recruitment of health professionals to rural areas. The Rural Health Policy Council has this agreement contract with the 3 R Net organization, which I think could be very effective in assisting with increased recruitment to the rural areas. And I was hoping that maybe we could find a way to improve that program, and the Rural Health Association would be interested in talking about how we might be able to assist with that program to look at that area.

INTERIM EXECUTIVE DIRECTOR LEE: I would love to talk to you about that.

CHAIRPERSON CARLISLE: Okay. Well, if there are no other comments, and no other questions or comments from the members of the Council, I think we will go ahead and bring the meeting to a close.

Oh, Mauricio, yes.

COUNCIL MEMBER LEIVA: Actually, I have one comment, and it has to do with recruitment. As you know -- is this on? As you know, the Executive Director of the Managed Risk Medical Insurance Board is leaving at the end of June, and our Chairman of the Board has asked us to let people know that that position is open and we are actively recruiting for the position. I believe that the deadline is tomorrow, but I'm not sure that -- I mean, they may be able

to extend it because they are on a fast track to fill the position.

So if anyone is interested, please help us recruit for that position, as well. Thank you very much.

CHAIRPERSON CARLISLE: Thank you, Mauricio.

And just one last announcement. Of course, the next scheduled meeting is tentatively scheduled at this point for the 6th of August, in San Diego. And the subsequent meeting I believe is going to be October or November?

INTERIM EXECUTIVE DIRECTOR LEE: We're still working on that. I think --

CHAIRPERSON CARLISLE: Yes, tentatively August 6th.

All right. Well, thank you very much for being here. It's great to be in Gualala -- I always have trouble pronouncing that name. Never been here before. And have a nice afternoon.

(Thereupon, the meeting of the California Rural Health Policy Council was concluded at 1:54 p.m.)

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CERTIFICATE OF REPORTER

I, JAMES RAMOS, an Electronic Reporter, do hereby certify:

That I am a disinterested person herein; that the foregoing Health and Human Services Agency, Rural Health Policy Council Meeting was reported by me and thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties in this matter, nor in any way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 1st day of July, 2002.

James Ramos

Official Reporter